Assessment of Active, Experiential Training on Program Expansion: Living University in the Positive Deviance/ Hearth Program in Vietnam

Consultancy Report

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Acronyms

CCF	Christian Children's Fund
CPCC	Committee for the Protection and Care of Children
GMP	Growth Monitoring and Promotion
GOV	Government of Vietnam
HPNMP	Healthy Pregnancy/New Mother Program
IMR	Infant Mortality Rate
INGO	International Non-Governmental Organization
LBW	Low Birth Weight
LU	Living University
MCH	Maternal Child Health
MOH	Ministry of Health
NERP	Nutrition Education and Rehabilitation Program
NGO	Non-Governmental Organization
NIN	National Institute of Nutrition
NNP	National Nutrition Program
NRLP	Nutrition Revolving Loan Program
PAM	Program Against Malnutrition
PANP	Poverty Alleviation and Nutrition Program
PAR	Public Administrative Reform
PD	Positive Deviance
PD/H	Positive Deviance/Hearth
PDI	Positive Deviance Inquiry
PEM	Protein-Energy Malnutrition
PHC	Primary Health Care
QSS	Qualitative Scaling-up Survey
RTCCD	Research and Training Center for Community Development
SCJ	Save the Children/Japan
SCUS	Save the Children/United States
TOT	Training of Trainers
VNFO	Vietnam Field Office
WU	Women's Union

[1] The population figure refers to the total population, not to the number of children under five years of age.
[2] However, in the case of Vietnam, UNICEF has reported the higher figure. For example, in its *State of the World's Children, 2000* (Table 2, Nutrition), UNICEF reports that 41% of the under-fives in Vietnam between 1990 and 1998 were moderately or severely malnourished (with 9% of them being in the severe category). It seems that UNICEF must have included the mildly malnourished in this figure.

[3] The exchange rate at the time of the study was VND 15,000 = US$1.

[4] While focus groups were to be held in 12 sites, one site had no LU graduates and one was incomplete and not useable.

[5] The factors are: leadership/ownership, a strong management information system (MIS), community empowerment, affordability, adequate funding, partnerships, intersectoral work, learning process, sufficient time, institution building, being alert to opportunities, strong training, participatory training, community financing, a clear conceptual underpinning, advocacy for policy, use of community volunteers, community mobilization, needs-driven priorities, flexible implementation, quickly visible successes, goal of scaling up from the outset, and attention to equi

Executive Summary

BASICS II commissioned a study of the Living University (LU) as a mechanism used by Save the Children/United States to scale-up the Positive Deviance/Hearth (PD/H) strategy in Vietnam. The study was carried out in three phases – design, data collection and analysis/presentation.

During the 1990s, Vietnam developed very quickly, with both economic and social indicators improving dramatically. This contrasts with 1991 when Save the Children/US (SCUS) opened an office in the country and began operations in Thanh Hoa Province. Among the under-fives in the original population of 20,000, the prevalence rate for malnutrition (weight for age) was 36% (6% severe and 30% moderate). After studying the well-nourished children among the poor population, SCUS identified special foods (e.g., snails, shrimp, crabs from the rice paddies) and behaviors (e.g., active feeding, feeding frequency). These foods and behaviors were then modeled for the mothers of the moderately and severely malnourished children at rehabilitation or hearth centers. The mothers of the children attending these centers brought the prescribed foods and assisted in their preparation to increase their feeling of participation and ownership. Mothers continued to attend these two-week Hearth sessions until their children were no longer malnourished, which took up to eight or nine months. The results were very impressive. After one year, there were no more severely malnourished children and only 4% fell into the moderately malnourished category.

Having proven the efficacy of the PD/H approach, SCUS expanded the PD/H approach to additional communes. Gradually other NGOs adopted the approach, were trained at the Living University (LU) or one of the two mini-LUs, and implemented it. The LU was an interactive learning experience based on problem-solving and emphasizing a hands-on approach. The trainees were exposed to every component of the program. By means of this mechanism, the PD/H approach was expanded so that it reached a population of over 2,300,000 in 384 communes in 61 districts in 22 provinces (out of a total of 61) by the time that funding came to an end and the LUs were closed in 2001.

The study consisted of two parts. The first was an open-ended **Qualitative Scaling-Up Survey** questionnaire that was conducted with officials at the provincial and district levels. This was to ascertain whether the SCUS's PD/H approach and the LU had had a lasting influence. It collected data on nutritional status, how they had heard of the PD/H approach, their views on the training and the influence of the program on how they carried out development. Focus groups were conducted in eight provinces: four that had SCUS involvement (one older, one newer, one seen as good, one as not so good); two with INGO activities (one Save the Children Japan (SCJ), one with Plan International) and two with no PD/H operations. Two districts were selected in each province. The second part of the study was the development of **case studies** on the experience of the three provinces that adopted aspects of the PD/H approach in their nationally-funded nutrition program.

The study found that the LU was an effective way to expand the PD/H approach and was superior to what was been done in the National Nutrition Program (NNP). Its content was judged to be appropriate, the training methodology productive, and development capacity improved in all sectors, not just nutrition. The volunteers at the community level learned quickly and effectively, and the mothers were empowered by the process. The LU and PD/H approach not only improved the nutritional status of the malnourished child but also younger siblings since the caretaker's knowledge and practices had been changed. Contrary to reports, there was no evidence that the quality of program in the newer communes was any less effective than earlier iterations despite greatly reduced supervision by SCUS.

The case studies of those provinces where the officials integrated the PD/H approach with the NNP demonstrated that it increased the effectiveness of the national program. In the case of Thanh Hoa, SCUS communes in operation for 12 months were able to reduce moderate and severe malnutrition by approximately 2 percentage points per month as opposed to less than 0.7 percentage points in the integrated programs operational for the same amount of time. This is three times as fast. In Thai Binh, there are data comparing three programs: PD/H, NNP, and integrated PD/H and NNP over a 9-month period. The NNP had the slowest percentage point reduction (between .13 and .37 per month). The integrated program was able to achieve faster improvement (.42 to .74 percentage points per month) while the SCUS approach performed best (slightly below 1 to 3 percentage points per month).

The study concluded that the LU was an effective means of expanding the PD/H approach. It allowed SCUS and other international non-governmental organizations (INGOs) to **replicate** the strategy. It was not scaled-up in the sense that it had neither been adopted by the government as the national program, nor had it influenced the NNP in training or behavior change communications methodology.

When considering what could have been done if the originators had desired to scale-up the LU and PD/H approach, several factors (Taylor, 2001) were identified that could have facilitated the process:

1. Goal: National coverage was not a stated priority of SCUS when the approach was originally developed.
2. Ownership: The government never developed a sense of ownership of the PD/H approach.
3. Champion: The approach never had a champion at the national level to promote its adoption.
4. Advocacy: With no champion and little sense of ownership, there was no one to push for the adoption or integration of the approach as part of the NNP.
5. Adequate Funding: For political reasons, all communes were given nutrition funds rather than having the available resources directed to those communes with the greatest need.
6. Need-Driven Priorities: Nutrition was less of a problem. Hence, it was less of a priority, and there was less demonstrable impact from the PD/H approach.

I. Introduction

A. Purpose

BASICS II conducted a study to increase understanding of the scaling-up process. The study of the Living University (LU) as a mechanism to scale-up the Positive Deviance / Hearth (PD/H) in Vietnam was part of an effort to review models for scaling up programs in several countries.

In Vietnam, the question to be explored was the effectiveness of the Living University as a means to expand the community-based PD/H approach that was launched by Save the Children/US (SCUS) in the early 1990s. The work began in four communes with a population of 20,000 and eventually reached approximately 2.3 million by the end of the decade, when the program came to an end.[1]

B. Study Phases

A team of two consultants worked with counterparts in Save the Children/US and Vietnam in a joint effort to assess the LU as a mechanism to scale-up the PD/H model. In accordance with the Scope of Work (*Appendix A*), the study consisted of three phases:

Phase I (8-18 January 2002) – Interviews of key informants from SCUS/ Vietnam; the government at the national, provincial, district and commune levels; international non-governmental organizations (INGOs) who had participated in the PD/H program; and multilateral donor agencies (e.g., UNICEF, World Bank) (*Appendix B*). In addition, the consultants reviewed a large volume of documents and reports on the 10-year project (*Appendix C)*. They also developed and tested several survey instruments to learn more about the role of the LU in the expansion of the model. These instruments included:

i) a provincial/district qualitative interview for 6 program provinces (4 SCUS and 2 INGO) and 2 non-program or control provinces;
ii) district quantitative survey; and
iii) guidelines for case studies on three provinces that had integrated some aspects of the PD/H approach with the National Nutrition Program (NNP).

Phase II (21 January – 16 March) – Data collection by the Research and Training Center for Community Development (RTCCD). They were responsible for both the qualitative survey and the case studies, while SCUS/Vietnam assumed responsibility for sending out the quantitative survey to the districts.

Phase III (18 –28 March) – Review and analysis of the data collected and drafting the report.

[1] The population figure refers to the total population, not to the number of children under five years of age.

This report is divided into several sections. After the Introduction, the second section, *Methodologies and Procedures*, will describe the study and instruments in more detail. The third section on *Background* includes a review of the nutrition situation in Vietnam over the past decade and background and description of the PD/H approach, the LU, and the National Nutrition Program. Some of the difficulties faced during the course of the study are also mentioned. The fourth section reviews the *Findings* of the study based on all data sources (interviews, documents and survey results). The final section of the report provides the *Conclusions and Considerations* based on lessons learned and best practices of the PD/H model in Vietnam.

II. Methodology and Procedures

The assessment of the effectiveness of the LU as a mechanism for the expansion of the PD/H program consisted of five different components: document review and archival research; key informant interviews; qualitative survey of program and non-program provinces and districts; case studies of provinces that had integrated PD/H with NNP; and a synthesis of scaling-up literature.

A sixth component was planned as a quantitative survey of program districts with data on malnutrition prevalence rates, current usage of any aspect of the PD/H program and any changes in way officers managed and implemented programs based on what they had learned at LU. This survey was sent to all districts that had participated in the PD/H program. For the 12 districts that had participated in the qualitative survey, there was sufficient data. For the remaining districts, however, despite several follow-up requests there was insufficient response to make the exercise meaningful. Because of the poor response rate, this aspect of the research was dropped.

A. Document Review

One of the important aspects of this assessment was the documentation and description of the PD/H approach as implemented by SCUC and others, and of the Living University. There has been a considerable amount written about the PD/H model as developed and implemented in Vietnam in general. Because of its success, a number of different aspects of the program have been studied: breastfeeding behavior (Dearden et al, 2001); empowerment (Hendrickson, 2001); scaling-up (Sternin, Sternin and Marsh, 1999); accurate weighing (Tuan, Huong and Thach, undated); and sustainability (Mackintosh, Marsh and Schroeder, 2000). For example, the Mackintosh, Marsh and Schroeder study found that growth promotion behaviors identified through the PD exercise and practiced in SCUS's rehabilitation sessions persisted three to four years after program completion so that younger siblings also benefited from the behavior change.

In addition, three evaluations of the effectiveness of the PD/H were conducted by SCUS, PLAN, and SCJ in the late 1990s. The Berggren and Tuan evaluation (1995) reported that there was a significant and sustainable decrease in malnutrition. Comparing the weights of under-threes taken at the first GMP session they attended in March 1991 to the weights at the last GMP session in September 1995, moderate malnutrition was reduced from 25% to 2% and severe malnutrition from 4% to 0%. The SCJ evaluation (Dibley and Tuan, 2001) also reported that the communes having the PD/H approach benefited from the intervention. The percentage of under-threes who were severely malnourished in the baseline survey in December 1998 was reduced from 9.9% to 2.5% two years later. This contrasts with the control population where the prevalence of severely underweight was similar (2.9% in 1998 to 2.6% in 2000). The collective assessment of the PD/H approach after all the various studies was that it was highly successful in bringing about a rapid reduction in the prevalence of moderate and severe malnutrition in Vietnam.

There is also data from a study of program processes of the latter stages of the PD/H that is still being analyzed. This information helped the authors of this assessment to gain an in-depth knowledge of the program over its ten-year history. The assessment team was unable to find any document that reviewed or evaluated the cost-effectiveness of the Living University experience.

A thorough searching of the archives was required to determine program coverage, both by SCUS and INGOs. Despite the best efforts of Save the Children over the years, there was no database established with the names of all communes and numbers of people trained. A certain amount of the institutional memory was lost over the course of the decade. Nonetheless, there was also considerable longevity and continuity among some of the PD/H staff, which made it possible to reconstruct accurately what had taken place and how. There were INGO sites where staff had been trained and the PD/H approach implemented that were not on the list. But since these had been carried out during the latter half of the 1990s, sometimes within the last few years, it was possible to get an accurate account by interviewing INGO staff and reviewing INGO records.

B. Key Informant Interviews

The key informant interviews were important at several different levels. To conduct these interviews the assessment team visited provinces, districts and communes that had been a part of the PD/H program in order to better understand what had happened on the ground. The team heard from those that had been involved in the program exactly what they did and how it worked. These interviews, combined with discussions with provincial and district officials who had served as part of their respective steering committees, gave the team an opportunity to learn about the program's strengths and weaknesses, and to explore and test important questions for the survey instruments as they were being developed. The managers and volunteers at the commune level were able to give the team a real sense of how the community participated in and benefited from the PD/H program, even though the program had stopped functioning over 18 months before the assessment in the country as a whole as much as six or seven years before in one of the communes visited. Even though the project had officially ended, health volunteers were still hard at work carrying out a number of initiatives, and they eagerly explained how their experience in the PD/H is being used in their everyday work. According to those interviewed, the successful sustainability was the result of unusually effective training and education methodologies that brought perceptible results and, as a consequence, lasting behavior change.

At the national level, the key informant interviews focused more on policy and program issues relating to both the NNP and the PD/H program. Officials in such agencies as Committee for the Protection and Care of Children (CPPC) and National Institute of Nutrition (NIN) spoke candidly about the strengths and weaknesses of the nutrition approach developed by SCUS and their impressions regarding why it was never adopted as the national model or used more extensively as part of the NNP.

Finally, key informant interviews were conducted at a number of INGOs. These interviews helped shed light on the expansion of the PD/H approach and how the approach is being used currently in Vietnam.

C. Qualitative Survey

The objective of the Qualitative Scaling-Up Survey (QSS) of provinces and districts was to ascertain if the Save the Children PD/H approach and the Living University had any lasting influence in the way that provinces and districts implemented development programs including the NNP.

The survey instrument is provided as *Appendix D*. The first section of the survey addresses the malnutrition prevalence rates in the province or district over the last decade, from before nutrition programming became widespread in the country to the present. There is a question on the factors responsible for the decrease.

The survey also included questions on how interviewees first heard about the PD/H approach to help the team learn how the model spread as well as the effectiveness of advocacy and dissemination efforts. It was also of interest to know why the provinces and or districts adopted the PD/H methodology.

In addition, there is a series of questions on training and the Training of Trainers (TOT) at the LU including its overall effectiveness and how the training changed the management approach at province and district levels during program implementation and long term. Special attention was paid to the innovative active learning aspects (e.g., role play). How important was the LU to increasing the knowledge and empowerment of trainees? Information on the composition of the Steering Committee and the long-term influence of the LU and PD/H on development programs in other sectors was also collected. Additional questions explored how the PD/H approach was or could have been integrated with the pervasive NNP. Ideas on why the PD/H approach was not integrated into the NNP and adopted nationally and important factors in explaining the effectiveness of the PD/H program were also included. The survey concluded with the interviewee's thoughts on implementing the PD/H approach more widely and what minimum level ("threshold") of under nutrition is required for the PD/H strategy to be effective.

The survey instrument was developed by the consultants together with Save the Children and RTCCD, which was responsible for conducting the survey. The questionnaire was pre-tested in the field to ensure that the questions were comprehensible and generated the desired data. Modifications in the organization and wording of the questions were made after field testing.

The QSS was carried out in a total of eight provinces. Six of these provinces were implementing PD/H programs including four by SCUS (Ha Tinh, Nam Dinh, Quang Ngai, Thai Binh), and two by INGOs (PLAN in Bac Giang and SCJ in Yen Bai). Two provinces did not have a PD/H program (Bac Ninh and Quang Ninh). (*Please refer to the map in Appendix E).*

Two districts were selected in each of these provinces. In each province there was an attempt to select a district which had communes implementing the old (comprehensive) model and one having the newer (condensed) version to get a broad view of experience. There was also an attempt to include districts that local officials considered good performers as well as ones that were not so good. It is important to note that there were no major differences in findings from the qualitative survey from SCUS and INGO districts regarding the PD/H approach, the NNP, potential for expanding the PD/H model, and the minimum level of malnutrition required for the PD/H strategy to be used effectively. The INGO interviews were not used when examining the effectiveness the LU because, while some INGO project partners attended the LU, many INGO partners were trained directly by their INGO partner, not LU staff.

D. Case Studies

The discussions with provincial and district officials during Phase I of the research revealed that three provinces attempted—on their own—to integrate aspects of the PD/H approach into their NNP. There was a need to know more about these three efforts to inform the discussion of how the PD/H approach could have been implemented nationally.

Researchers at RTCCD who were familiar with the PD/H approach spent a day in each of the three provinces to interview staff that had been responsible for or involved in the implementation of the integrated program in their respective provinces. The guidelines for the case studies instructed interviewers to include the following information:

♦ What Was Done – A description of exactly what the province and involved districts did. What components of the PD/H approach were integrated with the NNP and how? Was it the training content, training methodology, PDI, NERP, having mothers bring food and/or prepare it, etc.? The rationale for the integration and extent to which it was implemented was of greatest interest. Why wasn't it adopted on a broader scale and what would be required to reach a larger population with the integrated approach? In addition, how does the province compare the NNP, PD/H and the hybrid models, component by component?

♦ Impact – It is important to know how successful the respective approaches (NNP, PD/H and integrated/hybrid). The reductions in malnutrition prevalence rates by program were compared as was the length of time to achieve results.

♦ Costs – The costs associated with the three models are also important. As will be shown in the *Findings* section, the PD/H approach of SCUS is considered to be very expensive. Is this the case or does a cost-effectiveness analysis give a different conclusion? Are there components that could be adopted from one model that are not expensive but which increase the effectiveness of a hybrid version?

III. Background

A. Vietnam Setting

In many respects, Vietnam in the early 1990s was a very different place from Vietnam today. One important change has been impressive economic growth. "*Doi moi*" – economic reform – was launched in 1986 when the transition from the centrally planned economic system to a multi-sector "socialist-oriented market economy" began. There was rapid economic growth, averaging 9% per year between 1992 and 1997. According to World Bank and NGO surveys, poverty has been reduced from 70% of the population in 1990 to about 32% today (Michael Richardson, IHT, 21 March, 2002).

Significant strides were also made in the area of social development. Literacy rates are high, with 90% of the men and almost 80% of women considered to be literate. Some 92% of Vietnam's school-aged children are enrolled in primary schools and 57% in secondary schools. The country's infant mortality rate is 36.7 per 1,000 live births and the under-five mortality rate was 42 per 1,000 live births at the close of the decade. The contraceptive prevalence rate for modern methods was 60% in 1997. The result is a population growth rate of 1.64% per year during the latter half of the 90s. Vietnam's population is currently approaching 80 million.

At the same time, there were also administrative and structural reforms taking place. The Public Administrative Reform (PAR) strengthened the decentralization process, delegating more authority to the 61 provinces. As part of the reform, local participation was promoted through the 1998 grassroots democracy decree.

Agriculture is still a major component of Vietnam's economy with over three-quarters of the population residing in the rural areas. The country went from a rice-importing to a rice-exporting country. It is now the second largest rice exporter in the world. Despite this, the percentage of agricultural revenues contributing to the Gross Domestic Product is slowly shrinking and people are increasing moving from rural to urban areas.

Ten years ago, the country had a food deficit and the prevalence of malnutrition was very high. According to the 2000 Vietnam – Child and Mother Nutrition Situation, the prevalence of child malnutrition (mild, moderate and severe – less than 1 through 3 Standard Deviations from the mean, respectively) was 51.5% in a national survey in 1985 and 44.9% in the next national survey nine years later. The prevalence rates are not broken down into percentages for mild, moderate and severe. The rate of reduction was slow at only .66 percentage points per year on average.

In 1995, the government launched the National Malnutrition Control Program and developed the National Plan of Action for Nutrition. The prevalence of underweight children under the age of five began to fall rapidly. The rate of underweight children under the age of five in 2001 stood at 31.9%, including the mildly malnourished. Between 1995 and 2000, the rate of reduction in underweight under-fives fell at the rate

of 2.2 percentage points per year, more than twice the normal rate of reduction found in other developing countries. *Appendix F* gives a graphic presentation of this accelerated reduction in the latter half of the 1990s.

It is important to remember that numerous changes were taking place in Vietnam during this period. One important contributor to many of the changes mentioned above was the rapid economic growth that was taking place throughout most of the country. Another important contributor was an increase in contraceptive usage and the resulting sharp drop in the fertility rate. With less children to feed and longer intervals between births, the nutritional status of both the mother and child was greatly improved.

Vietnam did not achieve its goal in the National Plan of Action for Nutrition, which was 30% or lower underweight among the under-fives by 2000. However, when the national prevalence rate is disaggregated into mild, moderate and severe, the current nutrition situation in Vietnam is not a serious problem. According to the national data for 2000, only 5.4% are classified as moderately underweight and another 0.6% as severely malnourished in terms of weight for age. Some 82% of the underweight children (or 27.8% of the age group) fall within the mild category. It is not clear why the government includes the mildly underweight in the national figure – most countries do not and mild malnutrition is not included in the nutrition data in report such as the annual State of the World's Children[2].

At present, the largest concentration of malnourished children is found among the ethnic minority populations in the highlands. Ethnic minorities account for approximately 13% of Vietnam's population. The percentage of malnourished children in the Central Highlands, for example, is 45.4%, considerably higher than the national figure. Among the causes of malnutrition in the ethnic minority areas are high levels of poverty, food insecurity, and low level of literacy.

As mentioned earlier, aside from malnutrition rates in these ethnic minority communities, the overall improvement in nutrition has been impressive. There are a number of explanations behind this dramatic nutritional improvement in Vietnam over the last decade. However, global experience has shown us that an increase in income and education is not necessarily sufficient to improve the nutritional status of a population. There is often a significant lag before nutrition knowledge and practices change and yield improved nutritional status. In Vietnam, by contrast, the changes were rapid and, in this sense, the Vietnam experience is unusual and impressive.

[2] However, in the case of Vietnam, UNICEF has reported the higher figure. For example, in its *State of the World's Children, 2000* (Table 2, Nutrition), UNICEF reports that 41% of the under-fives in Vietnam between 1990 and 1998 were moderately or severely malnourished (with 9% of them being in the severe category). It seems that UNICEF must have included the mildly malnourished in this figure.

B. Positive Deviance/Hearth Program

An integral part of the assessment of the Living University was the review of the history of the PD/H program and its development and expansion. To illustrate the program's history and important milestones during its 10-year existence, a Chronology (*Appendix G*) has been constructed. This exercise was greatly facilitated by the contributions of five members of the original team responsible for developing and launching the PD/H program. Their efforts to make themselves available during the course of the assessment are greatly appreciated.

The Chronology begins with the initiation of the first four pilot communes in Thanh Hoa Province in early 1991, soon after the arrival in Vietnam by the first SCUS director, Jerry Sternin. The program covered a total population of approximately 20,000. Initially it was referred to as the Poverty Alleviation and Nutrition Program (PANP) and consisted of four components – Growth Monitoring and Promotion (GMP), the Nutrition Education/ Rehabilitation Program (NERP), the Nutrition Revolving Loan Program (NRLP) and the Healthy Pregnancy/New Mother Program (HPNMP). Approximately one year later, another ten communes were added to the PD/H program, increasing the total population four-fold to approximately 80,000.

The Positive Deviance (PD) approach as applied to nutrition, dates back to the late 1980s and the research funded by UNICEF (Zeitlin et al, 1990). The objective of the approach was to identify good child rearing behaviors in program communes despite impoverished conditions. In the early iteration of the PD/H program, poverty alleviation was included as part of the approach. This was dropped in the mid-1990s in an effort to streamline and simplify the program.

In the core nutrition component of the PD program, the first step in a new community is to find a well-nourished child (the "positive deviant") under the age of three in a poor family. Then a "Positive Deviant Inquiry" (PDI) is conducted, interviewing the family about their child feeding and care-giving practices. These interviews are analyzed to identify key foods and behaviors that have led to the superior nutritional status of the PD child relative to the other children living in the same impoverished conditions.

The information derived during the PDI exercise forms the content of the two-week NERP sessions that are modeled on the Hearth approach originally developed in Haiti by Drs. Gretchen and Warren Berggren at the Albert Schweitzer Hospital (Wollinka et al, 1997). The most malnourished under-threes identified at the growth monitoring sessions attend the NERP, which has two major objectives:

1 Rehabilitate malnourished children, and
2 Teach their caregivers how to sustain the child's improved nutritional status at home.

The PD behaviors are powerful in that they already exist and are being practiced in the community rather than imported from outside. The local foods identified in the PDI are prepared by the mothers themselves in the form of a nutritious, calorie-dense,

supplemental meal which is then fed to the malnourished children. In the case of the Vietnam program, the NERP was carried out six mornings a week for two consecutive weeks and included six guiding messages (*Figure 1*). Children continue to attend the NERP until they are no longer moderately malnourished (as measured by weight for age) or become less than two standard deviations from the mean. The daily "price of admission" for the mothers is a contribution of positive deviance foods. Some of the common foods found to be important in Vietnam are shrimp, crabs, snails (all of which are found in the rice paddies) and sweet potato greens that are readily and locally available but have not traditionally been fed to young children. The mothers are instructed to add PD foods not only to the meals they prepare at the NERP, but also to the children's meals at home. Once they see that children are able to digest the foods and their nutritional status and activity level improves, they become convinced that the approach makes sense and is the correct thing to do. It is a good example of participatory/experiential learning.

Figure 1: PD/H Messages

1. Breast milk is the best food for the child.
2. Children under three must receive a variety of foods 3-5 times per day.
3. From 4-6 months, children need to be given supplementary food in addition to breast milk.
4. Children need people to take care of them, feed them, play with them and guide them.
5. We can help prevent diseases from affecting children by keeping the house and children's bodies clean, giving children vaccinations and weighing them regularly to detect malnutrition early.
6. Families can improve their children's health at home by using the "good foods" available in the community.

It is not only the special PD foods that make the difference. Child-care practices were also found to be critical to improving children's nutritional status. Among the important behaviors identified by means of the PDI are the amount of time a parent or caretaker devotes to feeding the child, the frequency of feeding, better breastfeeding and health seeking practices, and improved personal hygiene. The poor mothers of well-nourished children were found to practice "active feeding", i.e., encouraging the child to eat, playing games during feeding, and devoting additional time to the process.

In 1994, the PD/H training had to be formalized as the model was now starting to expand more broadly. At this point training for the district and commune program managers was standardized as manuals were prepared. The Training of Trainers (TOT) was vital to the success of the program since those trained there would be responsible for training the commune volunteers and officials.

PD/H program data indicated that the nutritional status of the target population improved dramatically as a result of the program. SCUS selected locations that had worse

nutritional status than the country at large. Their baseline survey showed that in 1991, 68% of the under-three population was malnourished. Table 1 shows the dramatic impact that SCUS achieved in both the first four communes (launched in 1991) as well as in the second set of ten additional communes (begun in 1993).

Table 1: Results from First Communes Included in SCUS's PD/H Program (in %)

Communes/Time Period	Mild	Moderate	Severe
4 Original Communes			
Baseline (2/91)	32	30	6
Endline (12/93)	27	4	--
10 Additional Communes			
Baseline (4/93)	33	25	4
Endline (9/95)	29	4	--

The PD/H strategy improved the nutritional status of the newborns in target areas by improving the knowledge and behaviors of the mothers. The prevalence of low birth weight (LBW) births in the first four communes in 1993 amounted to 4% as compared to a national figure of 14% (UNICEF, 1992) and a provincial rate of 19% (NIN, 1991). In addition, nutritional status of all under-six month old children in the same first group of communes improved from 57% normal, 18% mild, 19% moderate and 6% severe in August 1991 to 78% normal, 18% mild and 4% moderate in December 1993.

The first of many PD/H program evaluations was conducted in mid-1995 (Berggren and Tuan, 1995). Evaluations were also carried out for the PLAN International PD/H program (Phoung et al, 2000) and Save the Children Japan (SCJ) effort (Dibley and Tuan, 2001). All these substantiate the effectiveness of the approach in dramatically improving the nutrition situation among the under-five population. In addition, the impact of the PD/H approach was sustained. Mackintosh et al (2000) found that not only were the growth-promoting behaviors and improvements in nutritional status sustained three to four years after the PD/H program came to an end, but the younger siblings of children who had attended the NERP and been rehabilitated were significantly better off that their cohort in a comparison village that had not participated in the PD/H program.

C. Living University

After the PD/H program was carried out in the original 14 communes, SCUS began to organize, systematize and formalize the training. First it developed the training materials. Then, in mid-1995, it established a Living University in Thanh Hoa Province, the site of their early PD/H activities. As the success of the early efforts became more widely known through organized workshops and seminars, the demand by INGOs and donor agencies (e.g., UNICEF) grew. The successful pilot experience allowed SCUS to develop a conceptual framework and identify essential components of the program—the PDI, training tools, conducting a NERP, development of counseling skills, mobilizing communities, and monitoring programming. This was included in ten training modules: one on household registration; four on growth monitoring and promotion (accurate weighing skills, filling out and explaining the growth card, counseling skills, monitoring

and evaluation); one on family visits and PDI; and four on the NERP (foods, behaviors, health care, monitoring and evaluation).

There was a concern that the early version of the PD/H or the PANP was too costly. This limited its broader application. Consequently, SCUS made a conscious effort to streamline the strategy to what it considered to be the essentials. SCUS's objective was to reduce the cost of implementation so that it fit what the implementing agency – the Committee for the Protection and Care of Children (CPCC) – had available to implement nutrition activities at the commune level. Thus, SCUS developed the consolidated version of PD/H the mid-1990s and the number of manuals was reduced to four (census/registration, GMP, PDI, NERP) while the length of training of trainers was decreased from ten days to four. This compares with two days of training in the NNP that was much less intensive, consisting of modest nutrition education and some supplementary food or a cooking demonstration. In addition, the provincial and district officials and steering committee members are typically included in the PD/H program and not included in the NNP.

The location of the Living University is important. It must be in close proximity to a successful model so that it can truly be *living*. The LU is a sequential learning process that combines the conceptual framework of the PD/H model with real life situations, providing an interactive (non-lecture) learning experience. The students work in the villages with members of the target population, just as if they were in their own villages. Learning at the LU is a problem-solving process and emphasizes hands-on, direct exchanges with experienced field implementers and participant families as well as other key community members. The classroom is situated close to a successful model at various stages of implementation so that the trainees are exposed to every component or phase of the program as it evolves in a community. It trained the managers and supervisors who are responsible for training the commune-level volunteers, the actual implementers of the PD/H program. The course for the commune volunteers was generally two weeks long, but the first three days were designed to include other key players from the provincial and district levels, e.g., Women's Union (WU), Committee for Protection and Care of Children (CPCC), health managers and staff and People's Committee leaders.

From 1994 to 2000, the LU also trained staff and project partners of 11 INGOs and donors (e.g., Terre des Hommes, Plan International, Care, SCJ, Redda Barnen, AFAP, German government technical assistance (GTZ), and the Christian Children's Fund) that went on to implement the PD/H project in 88 additional communes in ten provinces in their respective project areas. This added another half million people to PD/H coverage.

At the end of the course, all LU graduates (i.e., trainers) received a certificate of completion and returned to their project areas to implement the PD/H approach. The LU team visited the graduates periodically up to 18 months after training to observe and support their work and conduct problem-solving sessions. Tailored technical assistance was offered to all INGOs.

By 1996, the PD/H model was in the midst of a growth spurt and was fast approaching coverage of half a million population. As mentioned, to facilitate rapid expansion, the PD/H approach was condensed, focusing on the two major components, GMP and NERP. At the same time, the capacity of the original or "Mother LU" was no longer sufficient to handle the numbers that required training. Thus, the first "Mini-LU" was established in Quang Ngai Province in the Southern Central Coast Region. As the program grew to approximately a million only one year later, the second Mini-LU was started at Thai Binh Province. The Mini-LUs function much like the Mother LU – they train trainers using the same curriculum, same materials, for the same duration. They are merely additional training sites as the Mother LU became over-burdened and could not satisfy demand.

Some people refer to the training sessions for volunteers conducted at the commune level by those trained at the LUs as "mini-LUs". For the purposes of distinguishing the various types of LUs, we have given them the title of "Micro-LUs". Thus, the Living University hierarchy consists of the "Mother-LU" in Thanh Hoa, the two "Mini-LUs" and numerous "Micro-LUs" at the district/commune level.

The PD/H program and the LUs came to an end, at least formally, in early 2000 when funding was no longer available. Although it is not possible to get an exact figure for the number of people trained directly (at the LUs) or indirectly (by the trained trainers in the Micro-LUs), a review of all the records and documents available to SCUS and the researchers plus conversations with INGOs that had been involved in the PD/H program, it is possible to estimate that the total coverage of the PD/H approach reached 2.3 million in 384 communes in 61 districts in 22 provinces. Approximately 64% of the communes were part of the SCUS program; the rest were implemented by various INGOs.

As mentioned above, although the nutritional status of Vietnam in general has dramatically improved, there are still pockets of serious malnutrition existing in the country, specifically among the ethnic minorities that inhabit the highlands regions in more widely dispersed communities. This makes it very difficult and costly to carry out a PD/H program in these areas. They have not been covered in the PD/H program to date. However, SCUS is eager to adapt the model to these deprived areas and has applied for a Child Survival Grant from the Office of Private and Voluntary Cooperation (PVC) of USAID to work in two districts and 40 communes (approximately 90,000 population) in Quang Tri Province.

D. National Nutrition Program (NNP)

While SCUS was developing and growing the PD/H approach, the Government of Vietnam (GOV) was developing its own effort to address the high rates of undernutrition. This is referred to as the NNP, which, like the PD/H, has had several iterations since it was launched in the early 1990s as the Program Against Malnutrition (PAM). This program lasted for four years and included monthly weighing for the under-threes, with their weights plotted on growth charts. The malnourished children received "nutritional powder" and vegetable oil that were supposed to be used by the mothers to make cakes and pastries. Pregnant women were also given supplements in the form of fish powder,

sugar and milk. There was no emphasis on improving the nutritional knowledge or changing the feeding practices of caregivers.

In 1994, the government launched the National Programme of Protein-Energy Malnutrition (PEM) Control for Vietnamese Children. This effort placed a greater emphasis on improving nutrition knowledge and provided limited resources for rehabilitation feeding. It was implemented by the CPCC and overseen by district-level steering committees which often included representatives from district People's Committee, CPCC, Women's Union, Youth Union, and health officer responsible for Maternal and Child Health (MCH). The goal of the program was to reduce malnutrition to less than 30% of the under-fives by the year 2000. Children under the age of three were the priority group. The primary strategy to achieve this objective was to develop human resources from the central to the commune levels by increasing the health providers' knowledge of nutrition by providing extensive nutrition education, and making their work part of Primary Health Care (PHC). Communications materials and mass media (e.g., loud speakers, television, magazines, and newspapers) were used to disseminate nutrition messages. Resources were allocated for nutrition rehabilitation and education for severely malnourished children under five (VND 16,000/month for 3 months) and for pregnant women showing low weight gain (VND 12,000/month for 3 months)[3]. The commune collaborators gave instructions to the caregivers of the malnourished children on proper care.

Beginning in 1994, the NNP in the form of the National Programme of Protein-Energy Malnutrition Control for Vietnamese Children operated in all provinces but in only a portion of the districts (50% in 1994, 59% in 1995, 69% in 1996) until, in 1998, it reached 100%. The percentages of the communes covered by the government's nutrition effort was approximately 20% during the first three years, increasing to almost 32% (3,282) in 1997, covering 3.7 million children under the age of five. According to government data, between 1994 and 1996, the prevalence of moderate malnutrition in the program communes went from 43.7% to 38.9%, while severe malnutrition dropped from 9.3% to 8.0% (GOV, 1998). This is an almost 11% reduction in the prevalence of moderately malnourished children (versus a 5.6% drop in non-program communes) or, stated in another way, a reduction of about 1.5 percentage points per year. In the severely malnourished category, the reduction in the government program was almost 14% as opposed to no drop in areas not having the program.

It is important to underscore the extensive changes in philosophy, strategy, and distribution of funding that occurred in 1998 when the entire program was transferred from the CPCC to the MOH. According to National Institute of Nutrition (NIN) staff (and supported by extensive documentation), the NNP radically changed its overall scope when it was moved to MOH. Prior to 1998, when it was under the control of the CPCC, resources had been distributed based on malnutrition data. Beginning in 1998, the implementation of NNP by the MOH was driven by a philosophy of equity or full coverage rather than need. As such, the NNP began an effort to serve (and presently

[3] The exchange rate at the time of the study was VND 15,000 = US$1.

funds) programming in all communes in Vietnam although additional funds are provided to the poorer, less-developed communes.

Under the MOH, funding for nutrition was reduced significantly, more in terms of what was available in the communes having significant levels of malnutrition rather than in absolute amounts of resources. In 2001, the national budget for the NNP was US$2.3 million. The limited resources were divided between more than 10,000 communes. In 2002, the 3,042 communes designated as priority 1 (most needy) received a higher allocation (VND 6,500,000 or US$433) than priority 2 (VND 1,250,000 or US$83). With this budget, only a few demonstration feedings are offered. In most cases the food is provided by the NNP program and is prepared by the program implementers at the community level.

In terms of the content of the current NNP, there is some flexibility in the activities which are included in local operations. Recent focus group interviews and case studies conducted for this assessment revealed several key components that were consistently implemented across program locations. Activities found in most provinces and districts included dissemination of public health and nutrition information at public meetings and/or by loudspeaker announcement; growth monitoring of children; meal demonstration by local health staff and donations of money to families with severely malnourished children. Program activities were found to be inconsistently monitored and supervised from the district level. This raised concerns about the accuracy of the GMP data that was being collected and reported. Other activities mentioned during group discussions in provinces and districts included providing loans and donating food and milk powder. While they were rare, some interviews uncovered districts taking an active learning approach to the NNP. They asked mothers to practice preparing the meals and, in one case, requesting mothers to bring food to the meal preparation session.

In the NNP, as in any large-scale program, it is necessary to distinguish what was planned from what was actually implemented. In one case, data collectors found that while meal demonstrations were planned at the provincial level, this activity was not implemented in the communes "because staff from provincial to district to commune levels did not know how to carry out the activity due to a lack of training. Also, there were no meals or contributions from the mothers." There was little appreciation of why the contribution and participation were important. Moreover, because of the large number of districts per province and limited supervision, it was very difficult for provincial staff to comment on exactly which activities were implemented in each of them.

With the under-five nutrition situation in Vietnam being greatly improved, informants thought that the NNP should be concentrated on the communes having significant rates of malnutrition. Overall, a review of the NNP indicates that the promotion or education aspect of GMP was not adequately emphasized. Secondly, the rehabilitation of the severely malnourished was the most expensive component of the program, consuming 30-40% of the total budget while serving only 10% of the target group. Thus, while the severely malnourished may be helped, little is done to prevent undernutriiton from

occurring. Informants suggested that in the future, food demonstration should be part of the nutrition education activities for the entire community rather than rehabilitative and restricted to the seriously malnourished. It was also observed that the skill level of the steering committees at all levels and of the collaborators at the community level and their supervisors “was still fairly low”, requiring an intensification of training.

IV. Findings

The information gathered for this assessment provided numerous insights into the workings of the PD/H approach, the advantages of initiatives that are truly community-based, the very kinetic nature of development work, and the exceptional dedication and commitment of the people of Vietnam who worked and are still working to end malnutrition in their country. In an effort to uncover the essential elements for widespread program expansion, the analysis of findings has been focused on: 1) examining some of the similarities and differences in the PD/H Project and the NNP, especially the training of trainers component; 2) assessing the effectiveness of the LU in reaching its objectives; 3) analyzing the expansion of the PD/H program and the role of the LU; and 4) discussing the expansion of the PD/H model and factors contributing and limiting this process.

A. Comparing the NNP with the PD/H Program

While the purpose of this assessment is not to evaluate the PD/H model or the NNP, it is useful to understand the differences in programming as we explore training delivery systems and potential for expansion.

There are important similarities between the PD/H Project and the NNP. The overarching goal of both efforts is to reduce the number of malnourished children in Vietnam. Both programs include a critical growth-monitoring component used to plot progress. Both programs bring mothers together to demonstrate meal preparation, and both have supervision for commune implementers.

The major differences include the audience and allocation of resources, kinds of food that are used in the demonstrations, the teaching methodologies of rehabilitation, and the overall sustainability of results. As mentioned earlier in the assessment, the NNP serves all children in all provinces, districts, and communes in Vietnam while the PD/H Project focused attention exclusively on severely malnourished children in the poorest communes. These differing program theories could not help but influence the way nutrition training and information dissemination was carried out. For example, the NNP program assumes that most, but not all, mothers have access to nutritious food for their children and provides the knowledge necessary for families to make smart choices about what they feed their children in an effort to prevent malnutrition. The PD/H model, in contrast, begins with no such assumptions as it targets vulnerable families in poor communities who may have access to nutritious foods but do not know that they are healthy and/or appropriate for young children. As such, PD/H looks to PD families in the target communities to identify local foods which mothers are using, sometimes against tradition or taboos, to rehabilitate their children at no or very low cost. As a result, while the NNP uses purchased foods (which may or may not be locally produced) for its demonstrations, PD/H projects sites always use the PD foods of the target commune.

The NNP provides supplemental support for families with children in need as identified through the growth monitoring process. This support most often takes the form of food or monetary donations to those households. There is little or no behavior change effort to accompany the distribution nor is the mother involved or empowered by the process. This contrasts with the PD/H model that does not give food or money to families but shows them how to feed their children using the same foods and cooking methods of some of their peers. This approach is not only more effective is changing behaviors but is decidedly more sustainable. The basic underlying concept of PD/H has been absorbed well and continues to be a part of the thinking of those who were once involved in the program. In 7 of the 11 focus group discussions, participants spontaneously used the popular development metaphor of giving the hungry a fishing rod rather than the fish with the PD/H program. As far as we could determine, this metaphor was not used in the PD/H training, yet it has been seen by many to represent what the program was trying to accomplish. As one focus group participant from Y Yen District in Nam Dinh Province put it:

> *The best way to assist the community to develop is to provide the people with the knowledge to make improvements themselves. I mean giving them a fishing rod, not just a fish. Before the CENP started, I thought that providing money would help the poor to improve their lives. After the training, I understood that the knowledge or fishing rod was important, not just the fish.*

In addition to differences in foods and the way foods were used for rehabilitation, the mothers were educated using very different processes. The NNP utilized a one-way method of information sharing: messages moved from the nutrition specialists to families through the use of community meetings, loudspeaker announcements, posters, and other methods of dissemination. In 1998, based on the apparent success of the PD/H Project, the MOH included food demonstrations in its program guidelines. Provincial and district officials participating in the assessment focus groups explained that NNP demonstrations were held in many communes but only rarely were participants asked to contribute food or practice the new food preparation skills. This more traditional "chalk and talk" strategy ensured the exposure of a maximum number of people to nutrition messages and cooking guidance but does not result in behavior change or improvements in nutritional status.

By contrast, the PD/H model aimed to transfer information from PD mothers to their peers and not only allowed for but also encouraged questions and modifications to the rehabilitation strategy. Mothers were given the opportunity to express their concerns with the approach. Many were initially skeptical that the local foods could really make their children stronger and felt they needed "nutritional powder" or other expensive supplemental foods. As children's nutritional and health status improved, however, mothers were able to see results and those initially skeptical often became the strongest advocates for the PD/H.

Those interviewed for the assessment also made distinctions between the PD/H training of trainers mechanism – the LU – and the TOT for the NNP program. There is overlapping content in the two TOT programs: both stress the importance of and explain how to implement the GMP and feeding demonstrations for mothers. The LU also contained lessons on conducting a community census, plotting a growth chart, using the PD approach, communication skills and evaluation. In addition to content, the two training sessions used very different training methodologies. As mentioned earlier, the LU used a participatory two-way approach, while interviewees described the NNP training as one-way. Finally, the capacity-building elements differed between the two models, LU training was designed not only to train trainers to implement the PD/H project but also to empower them to think about solving development problems in a whole new way. The NNP training, if only by nature of its length, did not have this additional objective for its training.

The LU had three major phases in terms of structure. In 1994, with the birth of the first LU, a series of ten PANP manuals were used and training sessions lasted approximately two weeks. In 1996, the program, and the training, were divided into two separate pieces, one for child nutrition (PANP I) and another for women's health (PANP II). These shortened training sessions, on average, lasted eight days. Finally, in 1997 the LU condensed training to mirror changes in programming and the new training focused mainly on GMP and NERP, the education/demonstration/rehabilitation component. In its final phase, LU training lasted about six days. NNP training, because it was held in a simple lecture format, lasted two days. Focus group interviewees discussed the advantages of the longer, more in-depth training offered by the LU which allowed them more opportunity to gain experience and practice what they learned, but, at the same time, many noted the added expense that must accompany this lengthier training.

Focus group participants, case study interviewees, and key informants often made other more general comparisons between the two programs describing the PD/H model as more intensive, requiring more work to implement, more effective in decreasing malnutrition (based on informal observations), and having more enthusiastic trainers.

Past evaluations, especially Mackintosh, Marsh and Schroeder, 2000, have shown PD/H results to be sustainable. Once mothers know the PD foods and understand how to prepare them, their children – both those previously malnourished as well as younger siblings – become and stay healthier. In addition, these new cooking behaviors, as in any household, are shared with the next generation and community newcomers. Because data and anecdotal information were collected during the life of the project internally and externally, we know the effectiveness of PD/H. Unfortunately, we do not have similar documentation for the NNP although, as pointed out below, there are a few cases where data exist to compare the impact of NNP, PD/H and a combination of the two. While we know that malnutrition rates have sharply fallen in Vietnam, it is no doubt due in large part to improved economic and developmental conditions, not any specific nutrition program. PD/H accelerated the reduction in the communes where it was implemented.

B. Effectiveness of the Living University

The Living University marked the formalization of the PD/H expansion. In 1994, after three years of successful programming, requests from donors, INGOs, and districts began to pour into SCUS and staff simply could not absorb the work of expanding to additional areas. At the same time, SCUS staff was becoming increasingly confident of project effectiveness and felt the time had come to formalize the training process and move forward with project expansion. The combination brought about the publication of the first PD/H training manuals and the opening of the first LU in Thanh Hoa Province.

The pressures and opportunities behind the LU opening defined its overall goals:

- ♦ Train trainers to be able to effectively use and train others to use the tools of the PD/H Model including: Growth Monitoring and Evaluation; Positive Deviance Inquiry; Nutrition Education and Rehabilitation.
- ♦ Train trainers to use the interactive LU strategy including group discussion, role-play, and learning through practice.
- ♦ Increase the capacity of trainees not only for implementation of PD/H model but also by instilling skills that could be used in other areas of their work.

Assessment of LU effectiveness is based on the goals listed above.

The positive outcome results of past evaluations of the PD/H approach sited above strongly indicate that the training component of the PD/H project – the LU – was successful at district and commune levels. Results of this assessment further confirm these conclusions. Looking at focus group discussion data from ten SCUS sites,[4] a number of themes were identified. Focus group participants not only stressed a high level of satisfaction with the training they received, but they also demonstrated retention of knowledge by describing the training content and methodology in great detail. This is especially significant given that many of them had participated in the LU as many as eight years ago.

♦ *Content*: In terms of knowledge of content, some of the LU activities most frequently discussed were: weighing children; identifying nutritious foods by visiting many homes in the community and looking for healthy children in both poorer and more wealthy homes, finding out what they are eating; isolating positive feeding habits (e.g., active feeding, greater frequency, breastfeeding); looking for nutritious foods that were available to all, and convincing mothers to bring food to the NERP center. In Ky Anh District of Ha Tinh Province Project participants described PDI and NERP components from their LU training:

> *We visited poor and wealthy families with both healthy and malnourished children. From the visits, we trainees assessed and learned which foods of the available options were more suitable for children. In the NERP we*

[4] While focus groups were to be held in 12 sites, one site had no LU graduates and one was incomplete and not useable.

learned to encourage mothers to contribute available food such as vegetables from their garden, eggs, and shrimp. We also learned how to have mothers participate in the cooking, which helped change their childcare and feeding practices. And after mothers are trained, they would apply these lessons on taking care of and feeding children in their own homes. This was the greatest success of SCUS.

♦*Methodology*: Even more striking than the conversations regarding LU content, were the discussions on the training methodology. While terms such as active learning, learner-centered teaching, and inquiry-based learning are used in many current training programs, these ideas and certainly their implementation was very new in 1994 Vietnam. During this time, when lecture style teaching and knowledge banking were the norm, the LU's inquiry-based philosophy made a long-lasting impression on participants. All ten of the discussions with LU graduates in SCUS locations included positive and detailed commentary on methods used by LU trainers. Some of the practices highlighted by LU graduate are displayed in Table 2.

Table 2: Training Techniques

Training Technique	Frequency (per # focus groups)
Hands-on practice	10/10
Field trips	7/10
Trainees asking questions/2-way information dissemination	7/10
Small group discussion	6/10
Step-by-step instructions	5/10
Role play	5/10
Learning games	3/10

All these techniques were new and revolutionary in Vietnam at the time they were introduced. The participatory training methodology was highly favored by those attending the courses and, according to them, increased their interest and learning. They claim that it made them better trainers when they used the same techniques when they trained the volunteers from the communes.

As one group member from Nam Dinh Province elaborated:

In the past, I just learned information from one side. Trainers talked in the class and distributed leaflets to learners to read at home or just held short discussions in the class. There was no role play or practice in training courses. At the SCUS TOT (the LU), I learned how to provide training using participatory methods in the community. I also learned how to facilitate role play. At the LU, I was given the opportunity to practice these techniques and ask questions when I did not understand any of the specifics of the training program.

The newness as well as the effectiveness of the LU techniques and the clear and detailed nature of LU materials was echoed in INGO key information interviews as well as the three case studies. It is important to note that these techniques are now core activities in most INGO and many GOV sponsored training sessions.

♦ *Increased Capacity*: In addition to training trainers to use the PD/H model, the LU afforded trainees the opportunity to improve their management and training skills. This change in management has outlived the PD/H Project and LU itself. In ten focus group discussions, LU graduates discussed how they are using knowledge and skills from their training in their work today. Three prominent trends were uncovered by these discussions:

- LU graduates are using the active learning techniques from the LU in their jobs today
- LU graduates are now working with their subordinates and community members in a more collaborative way, and
- LU graduates are clearly and carefully planning their projects and monitoring for results.

In terms of training, many of the people selected as trainers for the PD/H Project are, at present, involved in implementing and/or supervising other training programs. They have taken many of the skills and techniques first introduced in the LU and are using them regularly in their work. Some of the most frequently mentioned strategies used today are creating a friendly learning environment by encouraging learners to ask questions and engage in discussions and use of hands on learning. One trainer from Huong Son District, Ha Tinh Province described a recent training session for junior staff:

> *A class was organized simply and informally. The training was organized in a house with some people standing and some sitting. Before working with SCUS we would have used a formal meeting hall. We put up a sign that reads "Welcome" to make participants feel comfortable when they enter the class. We are friendlier with trainees and we encourage them to ask questions and share their own opinions.*

As mentioned earlier, these new training techniques are now used throughout Vietnam and the interview participant would, most likely, have learned some or all of the active training techniques in the course of her work. Two things, however, are highly significant: 1) the trainer not only knows about techniques but is using them and 2) she credits the LU with providing her with the information, practice, and confidence that allows her to use them comfortably.

The second major increase in capacity for LU graduates was an increased understanding that their subordinates and community members in general have insights and answers to development problems. Most interview participants talked about the importance and utility of two-way information sharing. While many of them, no doubt, were participating in genuine knowledge sharing before the LU, the training they received cemented this strategy and made evident the benefits to all involved.

Finally, trainers described an improvement in their management capabilities as a result of LU training. That is, they described the need for and their ability to carefully design their projects to meet specific goals, formalize step-by-step plans for implementation, and supervise and monitoring for results. In Binh Son District, Quang Ngai Province LU graduates now use simple but powerful guidelines when participating in community development projects.

> *We now make action plans for all our activities, we make progress by following our schedule, and we supervise all activities after implementation.*

In addition to these three main areas, some LU graduates also mentioned the importance of having simple and clear messages and instructions and using the PD approach as well as the LU training mechanism in other sectors such as agriculture, family planning, and health and hygiene.

C. The Integrated Approach

Three case studies provided in-depth information on the integrated approach used in three provinces (Thai Binh, Thanh Hoa, and Quang Ngai). In two provinces the approach was adopted in a single district and replicated in numerous communes. In the third, it was used on the provincial level and widely replicated in four districts. These were the only provinces combining the PD/H approach with the NNP that the assessment team was able to identify. While there were minor design differences in the three locations, they did appear to be very similar in terms of overall strategy and activities implemented. It is important to note, however, that these three initiatives were not coordinated. They each grew independently from the belief that PD/H was the best model to address the problem of malnutrition. One interview described his experience as follows:

> *Back in 1994, I knew from my own experience that very few communes were actually holding the rehabilitation demonstration meals. Instead, volunteers often distributed money or sugar and milk to mothers of channel B, C, and D malnourished children. Some mothers simply used the money to buy food for the entire family. The volunteers were not concerned with how much the children benefited from the program.*
>
> *I heard about the different model from SCUS but I did not believe it could work. I thought it required a large budget and a lot of technical assistance. Only after visiting the SCUS in Quang Xuong, Thanh Hoa (the LU) did I think it might be applicable. In 1996, SCUS began work in our province in pilot two communes and I became more interested. I asked if I could attend the training at the LU and was accepted. Two other provincial staff and twelve district staff from Quang Ngai also attended. Soon we had 34 communes using the model. I knew it would be applicable in other communes so I modified the program and used it 21 additional communes as part of the NNP.*

In terms of scope, much like the PD/H Project, the integrated program targeted communes and children in greatest need of nutrition programming. The implementers all modified the PD/H program manuals to decrease the length of training and overall cost. Major modifications included eliminating the documentation on management and radically altering the household census plan.

For implementation, the three individuals relied on their training at the LU and their experience as trainers. Each of the graduates coordinated child nutrition surveys in program areas to identify target communes. In Quang Ngai districts, PDI was carried out in each target area. In the other two districts, PD information from other SCUS communes was used in the NERP. In all three cases, families identified in the surveys were invited to the NERP center to participate in the project. By limiting the audience, staff not only focused time and resources to families of the most severely malnourished children, but also changed the dynamic of information dissemination and training sessions by limiting the number of participants. Unlike NNP sessions that were sometimes attended by 100 to as many as 200 mothers, the nutrition demonstrations in Integrated Program communes were attended by no more than 20 mothers and their children. This allowed trainers to use the participatory, hands-on training they had learned at the LU and knew would have the greatest influence on mothers' behavior.

All case study informants agreed that the integrated approach was highly effective. The implementation in two of the three studies was described as more effective than the NNP but not as effective as the PD/H sponsored and supported by SCUS. In the third case study – the only one implemented from the provincial level – results were said to be very impressive and interviewees described the integrated program and its early results as similar if not identical to the PD/H projects supported by SCUS.

While the impact of these endeavors is indeed significant, even more important is the empowerment, ownership, and increased capacity of the trainers who – upon learning the model – saw its value, and made it their own. They each saw a serious malnutrition problem in their area and looked for the best solution. That solution involved leveraging the benefits of the PD/H model, seeking additional funding, *and* working within a reduced budget. Thai Binh, for example, was able to augment the NNP with elements of the PD/H approach with resources generated by local tax revenues (each household was required to give the commune 1-2 kilograms of rice after harvest). In all three cases, by condensing the PD/H model to meet their most immediate needs and integrating it with the NNP model (thus allowing them to use NNP funding), trainers were able to serve 54 additional communes and provide perhaps the best example of the effectiveness of LU as both a training system and mechanism for expansion.

D. Expansion and Scaling-Up

The discussion of program expansion is guided by the document entitled "Achieving Impact on Child Health at Scale" by Mary E. Taylor. This study commissioned by BASICS II and released for review in November 2001 is a comprehensive review of

numerous projects that expanded programming as well as a synthesis of academic literature on the phenomena of scaling-up. Using the Taylor framework as a guide, the assessment team considered the 23 factors[5] found to be associated with successful scaling-up. Some factors were considered as necessary for successful implementation of any size. These include: community empowerment, strong training, participatory training, community financing, use of community volunteers, and community mobilization. All of these important elements were strengths of the SCUS PD/H effort in Vietnam. While there is no doubt a strong causation between these factors and overall project success and expansion, they did not suffice to bring the project to the GOV's national health agenda. To examine the process of nationally scaling-up, other Taylor factors were considered.

After studying the ten-year history of the PD/H project, the assessment team determined that the model had been successfully **replicated**, but not successfully **scaled-up**. While the literature (including Taylor) does not distinguish between these terms, for the purposes of the LU study, an important distinction can be made. The term "replication" is used to describe the adoption and implementation of a project or model (in this case the PD/H Project) in new areas, thus increasing coverage by expanding the project area. In the case of PD/H, the model was the expansion by SCUS and adoption by INGOs whereby the model was expanded to provinces, districts, and communes over the ten-year life of the initiative. "Scaling-up" is used to indicate a project or model used at the national level serving the target group, in this case severely malnourished children, throughout the country.

Before examining how and to what extent the LU was used for expansion and national scaling-up in Vietnam, it is important to review, to the extent possible, LU goals and the thinking of program staff regarding the possibility for expansion. When the PD/H Project began, the goal of SCUS was to significantly decrease the incidence of malnutrition in target communes in such a way that results could be sustained over time regardless of the economic climate. As time passed, the objectives expanded to include empowerment of community volunteers (who had been an integral part of the project from the beginning) and increased capacity of trainers and other program practitioners. Over time, the project proved itself successful, and there was an increased demand for training that led to the opening of the first LU in Thanh Hoa Province in mid-1994. First, while that LU was established for the purpose of training more trainers and expanding activities to new program areas, the concept of using the LU for national scaling-up was never an explicit or implicit LU objective. When SCUS staff was asked about this point, most, thinking back almost ten years, replied that they were not thinking about national-scale expansion at that time; they were simply responding to the increased demand for training and were thrilled with the high levels of interest and enthusiasm from new provinces and districts as well as INGOs. While there are no doubt lessons to be learned from the SCUS

[5] The factors are: leadership/ownership, a strong management information system (MIS), community empowerment, affordability, adequate funding, partnerships, intersectoral work, learning process, sufficient time, institution building, being alert to opportunities, strong training, participatory training, community financing, a clear conceptual underpinning, advocacy for policy, use of community volunteers, community mobilization, needs-driven priorities, flexible implementation, quickly visible successes, goal of scaling up from the outset, and attention to equity.

experience in terms of expansion, it is important to bear in mind that SCUS was not originally intending to scale-up the PD/H methodology nationally. Therefore, the utility of the LU as a training delivery system for national scaling-up cannot be based wholly on the success or failure of expanding the PD/H approach in Vietnam.

As mentioned earlier, the LU was a successful vehicle for expanding project programming. After the opening of the Thanh Hoa "Mother" LU, SCUS was able to recruit participants from the provincial and district levels to participate in the PD/H project by inviting them to the LU to learn about and experience first hand the process and results of the project. In addition to the provinces and districts recruited by SCUS, a number of provincial and district leaders who approached SCUS to request invitations to the LU then went on to implement the PD/H model. As mentioned earlier, requests also came from INGOs who wanted to use the model in their program areas. In all 11 INGOs and UNICEF staff attended the LU, and they expanded the approach to an additional 88 communes by 2001.

At least 3 of the 11 INGOs are still using the model for nutrition programming and several have adapted it to address issues in other program areas. PLAN International/ Vietnam is using the PD/H approach in over 50 communes and this number is increasing. In addition, PLAN is actively exploring ways to use the PD approach in other areas of programming. With a country office of over 100 staff and programming well respected by both the GOV and the development community at large, it is significant that PLAN has not only continued its PD/H work but has truly integrated the approach into their country program philosophy. SCJ is another INGO actively using the PD/H model in Vietnam. SCJ, an INGO with proven success on the commune level, is actively using its modified model and also is involved with advocacy work to try to combine the SCJ PD/H model with the NNP with the goal of better serving isolated ethnic minority populations. Finally, the LU was also found to be an effective tool for international expansion with SCJ, SCUS, and SC/Norway staff from Nepal attending the LU and transplanting PD/H to Nepal.

While the LU has been an essential element of the program expansion in Vietnam, it was not used to scale-up the project nationally. Project design and a unique set of circumstances kept the PD/H model from becoming a national program. On the other hand, the approach was expanded significantly, using a *replication* strategy. In other words, SCUS and other NGOs adopted the same model and implemented it in a large number of communes, following the prescribed formula. The PD/H methodology was not scaled-up *per se* since it was not adopted by the GOV as the national or part of the national nutrition program.

The structure of the LU itself, however, was not a limiting factor in determining whether or not the model was adopted on a national scale. Among the reasons for replication rather than scaling-up was the fact that the PD/H model was found to be most effective in areas with higher rates of malnutrition, particularly severe malnutrition. When key informant interviews with former program management and staff reported that malnutrition rates that the PD/H model may not be the best approach in communities

where child malnutrition rates fall below 30 percent. The reason for this is two-fold. First, a measure of the effectiveness of the PD/H approach is, in large part, derived from the experience mothers have when they observe their children and other children in the community becoming healthier. In communities where there are only mildly malnourished children, mothers cannot easily observe the transformation in their children. In addition, like any initiative of this kind, the project can affect more change more effectively where the target group includes a larger percentage of the population. As the target group becomes smaller and smaller, it becomes increasingly difficult to attain and measure results. In short, as the economic situation in Vietnam improved, malnutrition rates decreased, as did the need for the PD/H Project. As mentioned earlier, attention now has to focus on the ethnic minority areas where economic development lags and malnutrition rates are high.

One important issue when considering program expansion is that of quality as it relates to program spread. While this assessment did not seek to measure the quality of PD/H programming across sites, SCUS staff and others have mentioned concerns regarding a decrease in overall quality as the project became larger and many project areas were not supervised or supported as intensively by SCUS staff. While review of available documentation did not point to a decrease in quality, anecdotal information and experience from other projects indicate that expansion carries with it an increased risk of quality decline or at least decreased monitoring and supervision leading to indeterminate quality. While this is not a reason to shy away from expansion, it is an important factor to consider when making programming decisions about expansion.

The factors sited in the Taylor paper that are related to the PD/H Project's replication rather than national-level adoption include the following:

- *Goal to scale-up from the outset*: It is well known, and often advocated, that consideration for program planning and evaluation should take priority at the earliest phase of project development. The same is true for scaling-up. In the case of PD/H, there was no explicit plan or strategy to scale-up when the effort was launched in Thanh Hoa Province in early 1991. Of prime concern was proving that the PD/H approach was effective. As it demonstrated impressive results and interest in the approach increased, pressure began to mount to reach larger populations. That is, attempts to enlarge the PD/H model were developed as the project grew in a largely *ad hoc* manner.

The results of the scaling-up process might have been different had SCUS and the primary GOV counterpart agreed and planned from the very beginning on the way in which the model would be applied to serve the most malnourished districts and communes throughout the country. As more is understood about the scaling-up process and essential factors are identified, it will be easier for project directors to develop strategies to reach a significant portion of a country's population when that, in fact, is most desirable. It is not being suggested here that the SCUS office should necessarily have planned to scale-up the PD/H model from the start, but simply that formal consideration for scope might have afforded SCUS increased opportunities to scale-up if

they have decided to include national scaling-up as a goal. According to an INGO key informant perspective:

> *In Vietnam, the PD/Hearth model has been replicated like wildfire but it has not been scaled-up. It just was not born that way*

• *Ownership*: In several discussions, including those with the originator of the PD/H approach in Vietnam, interviewees recognized that the lack of national-level ownership by decision and policy makers limited project expansion. Several reasons were given as to why this occurred. First, the program had to start very quickly, not giving sufficient time to develop the relationship and involvement required for true ownership by the government. When SCUS came to Vietnam in the late 1990s, the attitude towards Americans and American NGOs was circumspect; the Vietnamese had little confidence or trust in Americans. It was the beginning of the normalization of relations between the two countries, and time was required by both sides to heal the decades of estrangement. SCUS was told that in order to establish an office in Vietnam, they would have to demonstrate an impact in the area of child nutrition within the first six months in order to establish their capacity to contribute to Vietnam.

The Annual Report for the SCUS Vietnam Field Office (VNFO) for October 1, 1995 to September 30, 1996 contained a very revealing account of the constraints faced in influencing national policy. It mentions the political resistance to foreign models (i.e., those not seen as Vietnamese). Models can be adapted to the Vietnamese context after they are "Vietnamized." Only after this occurs can models from the outside be accepted. This sensitivity was extremely acute towards the adoption of foreign solutions to Vietnamese problems, especially in the field of poverty alleviation and in particularly in the area of child nutrition which was acknowledged to be a serious issue in Vietnam during the early 90s.

According to informants, and to further complicate matters, UNICEF and the World Bank afforded the PD/H Project extremely high visibility during the first few years of project implementation. This caused considerable resentment among Vietnamese institutions charged with addressing the malnutrition problem. These multi-lateral donor agencies encouraged the CPCC National Office, which was then responsible for the NNP, to adopt the PD/H model. As one early implementer explained: "CPCC was polite, made all the correct responses, but in fact was adamant to find their own solution."

Hurdles at the national level led SCUS to assume a lower profile and continue work at the other end of program operations, the commune. While the originator of the project saw this as a setback, other early implementers and INGO partners felt that continued work at the commune level would be an advantage in programming and help to maintain the integrity of this community-based program. As time passed, all reported that there was a need to expand to the districts and provinces. Gradually, SCUS involved more districts in more provinces. The CPCC staff who attended the LU returned to their communes and districts and began initiating the PD/H model but without any SCUS or US flag attached

to it. Some other provincial level CPCC colleagues were impressed and the model spread to Thanh Hoa, Thai Binh, Quang Ngai and other provinces.

As the CPCC increasingly used and supported the model, other Vietnamese institutions, which shared the mandate for malnutrition reduction, become interested in assuming responsibility for the NNP. In 1998, after the model was proven effective while the CPCC implementing the NNP, the MOH became managers for the NNP, and CPCC, at all levels, stopped work in the area of nutrition programming.

- *Champion*: According to Taylor (2000), the need for a national champion is included under the ownership factor. In the Vietnam case, the assessment team believes this factor is important enough to be addressed separately, examined at both the national and provincial levels. Because of the political challenges associated with the adoption of the PD/H model on a national basis, no one came forward as a strong advocate for national level adoption. At an early stage, SCUS attempted to involve NIN in the program and encouraged them to secund six staff members to work with the PD/H program and serve as trainers in the LU. Because of a general lack of interest at NIN, the individuals who were appointed did not hold policy-level positions or have access to decision makers. These individuals did, however, participate and they remained with SCUS for two years. At the end of this time, one retired, three were hired by INGOs and two returned to NIN where they were assigned to non-operations positions which prevented them from playing any role in promoting or advocating for a national PD/H model.

SCUS made efforts to advocate for the model at the provincial level as provinces have considerable latitude to implement programs they consider to be appropriate and effective; however, given that SC is an organization that values and operates effectively at the community level, they continued to focus considerable attention at the commune and district levels. What could have been achieved if SCUS had developed a strategy to more aggressively promote the PD/H model at the provincial level is not known.

- *Advocacy for policy*: Advocacy is identified as one of the critical aspects in the scaling-up process. Some of the problems associated with ownership and having a champion certainly overlap with the advocacy aspect. If there is not a feeling of ownership on the part of the GOV, any success or impact achieved is seen as a foreign effort and therefore remains suspect. Without the integral involvement of national policy makers, any advocacy carried out on behalf of the PD/H program would reinforce the perception of foreign ownership, thereby increasing resistance.

When considering how advocacy could have been done more effectively, several considerations were raised. For one, holding national or provincial workshops where local leaders or program managers speak about program successes and lessons learned would be an effective means of convincing others that the approach is practical and would achieve measurable results. A second means of improving national visibility would be to have national leaders speak and write (and have published in their names) articles on the effectiveness of the model. This would have increased the sense of

ownership while creating a champion and increasing the chance that the leader's organization would become a force behind the adoption and scaling-up of the model.

- *Adequacy of funding*: Conventional wisdom says that it is difficult to nationally scale-up an NGO-development model because NGOs receive general and flexible funding to which a nationally sponsored program would not necessarily have access. Pilot or demonstration projects are typically ambitious, often involving multiple and well-financed activities and components. The same can be said for the original PD/H project that was developed by SCUS in Vietnam. When the strategy was adopted on a broader scale and an attempt was made to link it more closely with the NNP in the mid 1990's, SCUS made a conscious effort to reduce costs by consolidating the program into its two most essential components GMP and NERP. (It is worth noting that the Iringa Project in Tanzania did the same thing in the mid-1980s before they scaled-up the model to 40% of the country, UNICEF, 1993). In the effort to consolidate, SCUS dropped the revolving loan fund and the maternal health component. Moreover, the intervention period was reduced from 18 to 10 months. The cost per commune was reduced to below $1,800 including the training, equipment, supervision, and volunteer stipends. This was very close to what the CPCC budgeted for priority communes (those with higher rates of malnutrition).

However, as SCUS restructured and consolidated the PD/H model to match it to CPCC resources, the MOH became the lead agency and the funding structure was significantly altered and reduced in high priority communes so that more, and eventually all, communes could be served. In 2001, the national budget for nutrition was US $2.3 million and this money was divided between more than 10,000 communes. While the 3,000 poorest communes received the more generous allocation, it was only enough to carry out a few feeding demonstrations. The funds were no longer adequate to implement the PD/H approach. Interestingly, neither the provision of food nor its preparation by the mothers was promoted even though it would have reduced costs.

While the cost of the PD/H approach may be high, it is spent within a short 9-month period. After this intensive period, severe malnutrition is eradicated and moderate malnutrition is almost eliminated in both the short and long term since child-feeding behaviors have been changed. Therefore, a cost-effectiveness study shows that the cost per unit of change (reduction in prevalence of malnutrition) of the PD/H approach is actually less than the NNP which is less intensive and has less impact on child feeding practices, meaning that malnutrition rates fall more slowly and the reduction may not be as sustainable. Thus, a case can be made that the PD/H strategy should be adopted as a cost-effective intervention.

- *Needs-driven priorities*: It stands to reason that interventions addressing national priorities stand a better chance of being scaled-up. Certainly malnutrition was a priority issue in the early 1990s when prevalence rates among preschool aged children were alarmingly high. The absence of a scaling-up strategy coupled with the ownership problems previously mentioned meant that SCUS was not able use this "need-created" momentum to promote the PD/H model.

In the last several years of the 1990s, the nutrition statistics in Vietnam markedly improved to the point where malnutrition was no longer a national priority. The goal of reducing under-five malnutrition to 30% by the year 2000 was close to being achieved and the GOV has marked a new goal of 20% to be met by the year 2010. But there are fewer communes with a significant portion of their children suffering from moderate and severe malnutrition. For the PD/H model to be effective and demonstrate the dramatic results that motivate behavior change in caregivers, a significant portion of the cohort must be seriously malnourished. While no one can be sure what the threshold of intervention—the minimum level of moderate and severe malnutrition—is, it is certainly higher than the percentages found in Vietnam today. Dibley and Tuan (2001) state that "at least 15% of the children less than three years old living in the project commune should be severely malnourished before implementing NERP." While that may be excessive, the point is that there must be a significant portion of the target population exhibiting a severe condition in order for the PD/H intervention to have discernable impact. Malnutrition, while an important issue in some isolated ethnic minority areas, may not be widespread or severe enough at present to make the PD/H model appropriate at the national or even provincial levels.

V. Conclusions and Considerations

The PD/H approach was highly successful in improving and sustaining the nutritional status of the under-threes in the almost 400 communes where it was implemented. The methodology is highly effective and should be considered in countries with high levels of malnutrition. Identifying local foods consumed and behaviors practiced by a minority of the community can empower individual caregivers, households and communities to breakdown traditionally-held taboos that are having a detrimental nutritional impact. This increased ability to appreciate the extent and nature of the problem and to identify feasible solutions radically changes the way the community addresses its development. If they are successful in nutrition, they gain confidence they can develop in other sectors, such as education, water and sanitation, and agriculture. While modified PD/H approaches have been used in a number of program areas including education, agriculture, and female genital mutilation, the PD/H approach has proved itself especially successful in the area of nutrition as results are immediate and clearly apparent to mothers, trainers, and INGO staff. While the PD/H approach/methodology may be a viable or even the best approach in other sectors, they may have the disadvantage of not having such tangible and immediate results as nutrition to fuel the effort.

The Living University was found to be an effective mechanism to train a volume of trainers in a short amount of time while controlling and sustaining the quality of the program. A detailed curriculum, training and teaching methodology was developed which produced a group of high quality district trainers who, in turn, trained commune managers and nutrition workers. The LU introduced not only new information and radically new ways of working with the community, but also innovative training techniques that differed dramatically from what had traditionally been done in Vietnam. The practical, hands-on approach was both accepted and gradually adopted on a broader scale. Such practices as role-play are no longer considered strange or foreign; rather they are appreciated and seen as a way to deepen understanding and improve performance in the Vietnamese context. Thus, if the country has a high prevalence of moderate and severe malnutrition and the PD/H approach is adopted in a country, the LU is a recommended way to increase its coverage.

It is important to add that that the effectiveness of the LU for program expansion is not limited to programming designed to alleviate malnutrition. The techniques and organization of the LU could be and should be considered when planning TOTs for projects in a variety of sectors. Core elements of the LU that should be included to achieve high quality training results similar to the PD/H LU include a carefully designed training manual. The LU manual for TOT trainers and other trainers contains a high degree of specificity to accompany clear, straightforward activities. The manual and its clarity were stressed as a LU and PD/H strength. The training methodology can also be easily carried over to other sectors. This includes LU field trips where trainees are able to observe program success and practice what they have learned. Active, inquiry-based learning techniques are also used in the classroom as well as the field. Key techniques that should be included are: role play where trainees can practice their new skills in a

supportive environment; small group discussion so all trainees have a chance to actively participate; and meaningful discussion and two-way question and answer sessions.

Returning to the question of expansion versus scaling-up, if the objective is to scale up programming, a number of considerations must be made from the very beginning, again, regardless of sector. First, the program must be clear in its objective, whether it is expansion, replication or scaling-up. The implications attached to each of these choices must be appreciated. If national scaling-up is the goal of a program, actions must be taken from the initial stage to ensure local ownership. This includes things like the name of the program. In the case of the PD/H in Vietnam, for example, the program might have been called the NIN or CPCC program rather than the SCUS or PD/H program.

Another important aspect to be considered if scaling-up of the PD/H approach is a goal, is how to involve and convince the decision-/policy-makers that it is the model that should be adopted nationwide. Various efforts were made by SCUS and success was achieved although it was mostly at the provincial and district levels. The national-level nutrition policy makers were reluctant to support the model for scaling-up and the most common reason given was high cost. While some of the costs associated with the PD/H program were more expensive (e.g., longer training, supervision), a cost-effective analysis will demonstrate that the approach is actually less costly. A three-step approach is suggested for convincing the national decision-makers that the innovative nutrition intervention should be considered for national implementation:

i) Include a group of the most important ***policy-makers*** in an early PD/H ***training*** exercise. They should experience the LU just like the provincial and district-level officials did, but should be among the first to experience the approach. It is often crucial that decision makers be the first program allies so they have ownership from the start. The LU convinced province- and district-level officials of project effectiveness and would very likely to do the same in the case of the national-level officials. Going through the experience themselves and witnessing first-hand how the PDI and the NERP exercises result in positive changes in infant and child feeding practices would help convince the national decision-makers of the validity and value of the approach.

ii) The ***impact*** of the approach should be reported and shared with the decision-makers on a regular basis, preferably by the provinces involved rather than by the supporting INGO. The provinces should become the advocates for the methodology and make a case for why the approach would result in the most positive results and achieve national nutrition goals most rapidly.

iii) Greater effort should be made to track the ***costs*** of the innovative approach to demonstrate how it can be implemented despite limited public resources. The PD/H approach was condensed to minimize costs, both in length of training and in duration at the site. Until that point, SCUS had attempted to bring the cost of the PD/H approach as close as possible to the national program so that

it was a viable national option. However, once the MOH assumed responsibility for the NNP and resources were dramatically reduced, any desire to expand on a national level was abandoned. A good economic analysis could have identified the shortcomings of the national approach and presented a strong option based on a more targeted approach utilizing the PD/H methodology. Teaming with interested parties (e.g., INGOs, the World Bank, UNICEF), a nutrition task force could demonstrate how a PD/H strategy could rapidly decrease the prevalence of moderate and severe malnutrition and sustain the improvement. The distinction between the cost and cost-effectiveness of the various program options should be made and considered.

To close on a broader note, we as development professionals, policy makers, and grass-root practitioners would do well to reflect on ***how NGOs and governments can collaborate*** more successfully. Governments and NGOs have complementary strengths and, by working together, they would be stronger and achieve better results than working alone. NGOs, like SCUS and others involved in the PD/H program in Vietnam, are effective in empowering communities and implementing social programs at the community level. The strengths of governments, in contrast, generally lie in the policy arena. Typically INGOs have had little success in guiding national policies just as governments have been limited in their ability to develop dynamic grassroots programming. Governments have political agendas that require them to address the needs of the entire population rather than only the most adversely affected while INGOs are very targeted, focusing exclusively on their impact on specific populations. In addition, bureaucracies, by their very nature, are more procedure-oriented while INGOs because of funding requirements tend to be highly results-oriented.

By combining forces to address national priorities, governments and INGOs could make even more significant contributions to people they serve. Only when partnership between the two is truly genuine and these two organizational cultures have opportunities to work closely together can trust develop between individuals and eventually between organizations. Only if and when this occurs can the practice of INGOs operating separately on a reduced scale while the government works alone on a national scale give way to a joint effort, pooling and leveraging resources for the good of the country and those in greatest need. In short, if the challenge of scaling-up is to be addressed and progress achieved, we must make greater efforts to bring NGOs and the public sector into a closer working relationship.

Appendix A: Scope of Work

Partner Employee's Name: David Pyle

Time Frame: September 1 – December 31, 2001

Supervisors: Paul Ickx, Director OER; Karen LeBan, PVO Liaison

Deliverables:
Phase 1: 3 days: Preliminary assessment design and protocol
Work with BASICS and Save the Children colleagues to develop an initial design and protocol for the Assessment of the Living University used by Save the Children in Vietnam to expand the Positive Deviance / Hearth program to over 2 million people over a period of 7 plus years. This design and protocol will be based on quantitative data provided by SC/Vietnam such as on the numbers of districts reached, mini-living universities created, number of MOH or NGO personnel trained, current status of existing living universities or PD/Hearth sites. The design will build upon key BASICS experiences, lessons learned and program framework for assessing and designing programs that work "at scale".

Phase 2: 11 days: Detailed assessment design, protocol, timeline, tools
Travel to Vietnam to work with Save the Children/Vietnam team to collect preliminary information through initial interviews and focus groups; develop, test, and finalize assessment tools; train SC managed team in the use of the tools; and develop a detailed assessment design, protocol, and timeline for completing the assessment. The team leader will consult with BASICS staff by e-mail / phone to ensure that the design and tools are mutually acceptable by BASICS and SC.

Phase 3: 16 days: Technical assessment report containing description of living university process, data analysis, key findings, conclusions, lessons learned
Provide technical advice to SC-managed team during data collection period, as needed. Travel to Vietnam to work with SC-managed team to analyse data and synthesise findings. Write draft final technical assessment report based on draft table of contents negotiated between SC and BASICS. Submit final report to BASICS incorporating comments provided by SC and BASICS.

Timeline:
Phase 1: 3 days between mid September and early October; product due by October 8
Phase 2: 11 days between late October and mid November; product due by November 15
Phase 3: 16 days mid November through December; product due by December 31

Appendix B: List of Persons Interviewed

Save the Children/Vietnam

Matthew Frey	Country Director
Ngo Thu Hang	Senior Program Officer (former LU Coordinator)
Doan Anh Tuan	Director, Economic Opportunities (former M&E Director)
Sam Sternin	Program Associate
Jerry Sternin	Former Country Director
Monique Sternin	Former Health Manager
Nguyen Thanh Hien	Former Deputy Director
Than Thi Lang	Former Director, Living University

Save the Children/US

David Marsh	Senior Health Adviser

Save the Children/Japan

Koichiro Watanabe	Representative
Nguyen Linh Van	Program Coordinator
Tran Huong Lien	Program Officer

PLAN

Mark McPeak	Country Representative
Le Quang Duat	Program Support Manager

Christian Children's Fund (CCF) of Australia

Nguyen Thanh Hien	Program Officer
Ms. Minh	Former Field Program Officer

UNICEF/Vietnam

Tran Khac Tung	Assistant Program Officer – Health Education
Dr. Nguyen Dinh Quang	Assistant Program Officer – Health & Nutrition

RTCCD

Tran Tuan	President
Van Thuy Huong	Researcher
Nguyen Quynh Hoa	Researcher
Mr. Thach	Data Manager

Committee for the Protection and Care of Children (CPCC)

Nguyen Trong An	Deputy Director (Planning and Nutrition)

National Institute of Nutrition (NIN)

Nguyen Cong Khan	Vice Director
Nguyen Do Huy	Program Officer

Thanh Hoa Province

Nguyen Van Thanh	Thieu Hoa District, People's Committee, Vice-Chairman
Le Ngoc Quy	Nong Cong District CPCC
Nguyen Huy Thanh	Provincial CPCC
Dong Thi Tinh	Nong Cong WU
Pham Huu Dan	Nong Cong District People's Committee – Vice-Chairman
Mr. Tinh	Minh Nghia Commune, Health Worker
Mr. Thao	Minh Nghia Commune People's Committee Chairman
Mr. Hy	Head, Minh Nghia Commune Health
Nguyen Nam	Ha Trung District CPCC
Dr. Khang	Ha Dong Commune Health

7 Ha Dong Commune Health & Nutrition Volunteers

Ha Nam Province

Dr. Bui Thi Hong	Director, Kim Bang District Health Services
Le Thi Vinh	Staff, Kim Bang District Health Service
Nguyen Thi Ty	Staff, Kim Bang District Health Service
Tran Thi Tuyet	Vice-Chair, Kim Bang Commune WU

Appendix C: References

Berggren, G., Nutrition Education and Rehabilitation Program: A Save the Children Project in Vietnam, in *Hearth Nutrition Model: Applications in Haiti, Vietnam and Bangladesh*, edited by O. Wollinka, E. Keeley, B. Burkhalter, N. Bashir, Washington, DC: BASICS, 1997.

Berggren, G. and T. Tuan, Evaluation of the Save the Children/US Poverty Alleviation/Nutrition Program (PANP), Thanh Hoa Province, Vietnam, November 1995.

Conrad, V., Preliminary Data from Study 1 of Linkages Positive Deviance Project in Vietnam, CENP Activities (Training of Trainers, Census, Growth Monitoring and Promotion, PDI, NERP and Deworming), 2002.

Dearden, K. et al, Work Outside the Home is the Primary Barrier to Exclusive Breastfeeding in Rural Vietnam: Insights from Mothers who Exclusively Breastfed and Worked, submitted to *American Journal of Public Health*, 25 April 2001.

Dibley, M. and T. Tuan, Evaluation Report: Save the Children – Japan Integrated Child Nutrition Project, Thanh Hoa Province, Hanoi: Research and Training Center for Community Development, February 2001.

Government of Vietnam, Investment for Child Nutrition in Vietnam: Child Malnutrition Control Strategy, National Plan of Action, December 1998.

Linkages, Process Evaluation Data and Codebooks, Washington, DC: Academy for Educational Development, undated.

Mackintosh, U., D. Marsh, D. Schroeder, Sustained Positive Deviant Child care Practices and Their Effects on Child Growth in Vietnam, submitted to *American Journal of Public Health*, September 20, 2000.

Marsh, D., Positive Deviant! Learning from Well-Nourished, Poor Children, undated.

Ministry of Health, National Strategy of Reproductive Health (for the 2001-2010 Period), 28 November 2000.

Ministry of Health, Planning Department, Health Statistics and Information Division, Health Statistics Yearbook, 1998.

National Institute of Nutrition, The National Goal for Child Malnutrition Control, 1999 Vietnam – Child Nutrition Situation, Hanoi: Medical Publishing House, 2000.

_____, 2000 Vietnam – Child and Mother Nutrition Situation, Hanoi: Medical Publishing House, April 2001.

Pasha O., An Analysis of the Community Empowerment and Nutrition Program (CENP), Process Evaluation Data, Save the Children/USA, 2002.

Phuong, D., et al, Poverty Alleviation and Nutrition Project Vietnam (PANP) – Final Evaluation Report (PLAN), Hanoi: Research and Training Center for Community Development, September 2000.

Save the Children/US-Vietnam Field Office, Annual Report, October 1, 1994 – September 30, 1995.

_____, Annual Report, October 1, 1995 – September 30, 1996.

_____, Positive Deviance/Hearth – Nutrition Program (rough cut video) – 1 October 2001.

_____, Proposal for Poverty Alleviation and Nutrition Program Expansion, 1994.

_____, Training of Trainers Manual – Positive Deviance Poverty Alleviation and Nutrition Program, November 1997.

Sternin, J., Living University – Program Site for Sharing the Experiences and Tools of Successful, Small-Scale Programs (draft), Save the Children, January, 2000.

_____, Poverty Alleviation and Nutrition Program, p. 145-157, publication unspecified, undated.

Sternin, M, J. Sternin and D. Marsh, Scaling Up a Poverty Alleviation and Nutrition program in Vietnam, in *Scaling Up, Scaling Down: Overcoming Malnutrition in Developing Countries*, ed. T. Marchione, Gordon and Breach Publishers, July 1999.

_____, Designing a Community-Based Nutrition Program Using the Hearth Model and the Positive Deviance Approach – A Field Guide, Save the Children, December 1998.

_____, Sustainable Childhood Malnutrition Alleviation through a Positive Deviance Approach in Rural Vietnam: Preliminary Findings in *Health Nutrition Model: Application in Haiti, Vietnam and Bangladesh*, edited by O. Wollinka, E. Keeley, B. Burkhalter, N. Bashir, Washington, DC: BASICS, 1997.

Sternin, S., List of Living University Graduates and Living University Chronology, December 2001.

UNICEF, "We Will Never Go Back" – Social Mobilization in the Child Survival and Development Programme in the United Republic of Tanzania, 1993.

Taylor, M., Achieving Impact on Child Health at Scale, Washington, DC: BASICS II, November 2001.

Toan, N., L. Huong, H. Thang, Final Evaluation Report – Maternal Health and Child Nutrition Program Vietnam 1998-2001, December 2001.

Tuan, T., V. Huong, T. Thach, Accurate Weighing of Children under 3 Years Conducted by Commune Volunteers, draft, undated.

Appendix D: Questionnaires

Focus group discussion questions for *Provincial Level* Informants
Sample: 4 SC/US Provinces, 2 INGO Provinces, 2 non-PD/Hearth Provinces

Please collect all the names, titles, and organization or affiliation of each of the focus group participants.

Questions for all focus groups:

1. Does your province have a nutrition program in operation these days?
   - ❖ If so, please describe the strategy being used.
   - ❖ How was it developed?
   - ❖ Where is it being used? In which districts? Communes?
   - ❖ When was it first implemented?
   - ❖ Where does the nutrition program funding come from?

2. What were the malnutrition rates in your Province in or around 1993?

3. What are the malnutrition rates for your Province now?

4. What factors contributed to the change in malnutrition rates?

5. Have you heard of the PD/Hearth approach (or use SC/US nutrition program)?
   - ❖ If yes, how did you first hear about it?
   - ❖ Who told you about it?
   - ❖ What did you hear about it? Content? Successful/not successful?
   - ❖ When did you first hear about it?

6. Did your province ever use the PD/Hearth model to address malnutrition?
   - ❖ If yes, what made you decide to use it?
   - ❖ If no, why did you decide not to use it?

7. In the past 10 years, did you use any nutrition program other than the PD/Hearth model and the National Nutrition Program?

- ❖ Did your Province design or adapt any other nutrition strategies?
- ❖ Did any INGOs or Donors support nutrition work in your Province?
  - ❖ If yes, please describe.

Questions for SC/US, INGO, and other provinces using the PD/Hearth model:

8. Did you attend the SC/US TOT or part of the TOT?

9. Did you enjoy the TOT? Why or why not?

10. What was the most important thing you learned in the TOT?

11. Was the TOT different from other training sessions you had attended?
    - ❖ If so, please describe.

12. Were there any training techniques used in the TOT that you are able to use now?
13. Did the TOT change the way you manage your staff?
    - ❖ Is yes, describe before the situation before the TOT and now.

14. Did the TOT that change the way you manage programs?
    - ❖ Is so, describe before the situation before the TOT and now.

15. Are you using PD in any other programming in your Province?
    - ❖ If yes, please describe.

16. Did the TOT change the way you think about development?
    - ❖ If yes, please describe.

17. Do you interact with the community differently than you did before the TOT?
    - ❖ If yes, please describe.

18. What were the difficulties in achieving the objectives of the PD/Hearth model?

19. Was the PD/Hearth model used province wide?
- ❖ Why or why not?

20. Why do you think the PD/Hearth model was not used Nationwide?

21. Have you been able to use what you learned in the TOT when implementing the National Nutrition Program?
- ❖ If yes, please describe.

22. How could we change the PD/Hearth model for use on a national level?

23. Was it used in any districts in conjunction with the national program?
    - ❖ If so where?
    - ❖ Please describe.

24. Was the Save the Children Nutrition Project successful?
    - ❖ If so, what 3 aspects where crucial to its success?

21. Did the PD/Hearth model have a champion or supporter on the national level?
    - ❖ If so, who was it?
    - ❖ Did they try to promote the model on a national level?
    - ❖ What was the result?

22. What level of malnutrition is necessary for the PD/Hearth model to be a cost effective method for addressing malnutrition?

Interview questions for *District Level* trainers and other district level key informants:

Please collect all the names, titles, and organization or affiliation of each of the focus group participants.

1. What were the malnutrition rates in your district in or around 1993?

2. What are the malnutrition rates for your district now?

3. What factors contributed to the change in malnutrition rates?

4. How did you first hear about the PD/Hearth approach (or use SC/US nutrition program)?
   - ❖ What did you hear about it? Content? Successful/not successful?
   - ❖ When did you first hear about it?

5. Why was the PD/Hearth model used in your district?
   - ❖ Who decided to use it?

6. In the past 10 years, did you use any nutrition program other than the PD/Hearth model and the National Nutrition Program?
   - ❖ Did your district design or adapt any other nutrition strategies?
   - ❖ If yes, please describe.

7. Did you attend the SC/US TOT or part of the TOT?

8. Did you enjoy the TOT? Why or why not?

9. What was the most important thing you learned in the TOT?

10. Was the TOT different from other training sessions you had attended? If so, please describe.

11. Were there any training techniques used in the TOT that you are able to use now?

12. Did the TOT change the way you manage your staff?
   - ❖ Is yes, describe before the situation before the TOT and now.

13. Did the TOT that change the way you manage programs?
   - ❖ Is so, describe before the situation before the TOT and now.

14. Are you using PD in any other programming in your district?
   - ❖ If yes, please describe.

15. Did the TOT change the way you think about development?

- If yes, please describe.

16. Do you interact with the community differently than you did before the TOT?
    - If yes, please describe.

17. Did your Provincial level counterpart attend the TOT?
    - If yes, has his/her supervision changed as a result of the training?
    - If yes, please gives examples.

18. What were the difficulties in using the PD/Hearth model at the commune level?
    - If yes, please describe.

19. Was it used in all communes?
    - Why or why not?

20. Why do you think the PD/Hearth model was not used in all communes in your district?

21. Was it used in any communes in conjunction with the national program?
    - If so where?
    - Please describe.

22. Have you been able to use what you learned in the TOT when implementing the National Nutrition Program?
    - If yes, please describe.

23. Was the Save the Children Nutrition Project successful?
    - If so, what aspects where crucial to its success?

24. How often did you (if you are a trainer) visit the nutrition program sites in your district?
    - What, if any were the limiting factors?

25. Did the PD/Hearth model have a champion or supporter at the Provincial level?
    - If so, who was it?
    - What was the result of this support?

Appendix F: Prevalence of Underweight Children (From 1985 - 2001)